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Independence Plus
A Demonstration Program for Family or Individual Directed Community Services Waiver
§ 1915 (c) of the Social Security Act

Created by:

Center for Medicaid and State Operations

NOTE: This document has not yet received OMB approval of the information collection pursuant to the Paperwork Reduction Act.

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Template for *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services 1915(c) Waiver Application

I. State Proposal Information

The State of ___**New Hampshire**___ requests approval of a Medicaid Home and Community-Based Services (HCBS) Waiver under the authority of Section 1915(c) of the Social Security Act. The program, to be entitled: **_In Home Support Waiver for Children with Developmental Disabilities_** will allow Medicaid beneficiaries to arrange and purchase family and individual supports and related services as described below. The proposed effective date of this waiver program is _____**January 1, 2003** _____. Initial waivers are approved for three years. Renewal waivers are extended for five years.

Line of Authority for Waiver Operation: (**Note**: The State Medicaid Agency is ultimately accountable for the operation of the program, but may allow daily operations to be managed by another entity of State government.) Check one:

___**X**__ The waiver will be operated directly by the **Division of Developmental Services** Unit of the State Medicaid Agency/Single State Agency.

Note: The Division of Developmental Services, in collaboration with departmental staff, contract agency staff, consumer advocates and family members, has drafted a proposed State rule (He-M 524) for this waiver program. [A copy of the draft is included with the supplemental documents.] The State will finalize this rule and submit it to CMS once the proposed waiver is approved.

It should also be noted that the waiver policy and procedures in this application were developed in collaboration with the participants in NH's Children's Mental Health initiative, Care NH, awarded by the Federal Substance Abuse, Mental Health Services Administration, NH's Department of Education's federal State Improvement Grant, advocates for children and families with special needs, and departmental staff involved in family support and Medicaid state plan.

_____ Operational management and responsibilities of the waiver will be carried out by _____ (another State Agency) and will be subject to an explicit interagency agreement that ensures for accountability and effective management for all requirements and assurances under this waiver. The single State Agency will retain the responsibilities of issuing policies, rules and regulations concerning this waiver. A copy of the interagency agreement setting forth the specific agency responsibilities and authorities is attached and is made pursuant to Section 1902(a) of the Act and 42 regulations at 42 CFR 431.10 which stipulates the roles and responsibilities of the single State Agency.

II. General Description of Program

those individuals who require long-term supports at a level typically provided in an institution, as specified in this application.

(Additional information, specific to the State administration is included in Appendix A.)

III. Assurances

The State provides the following assurances to CMS:

Health & Welfare - Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards are described in **Appendix B** and include:

A. Adequate standards for all types of providers that furnish services under the waiver;
B. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished; and
C. Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities.

Check one:

___**X**__ Home and Community-Based Services will not be provided in facilities covered by Section 1616(e) of the Social Security Act.

_____ A list of facilities covered by 1616(e) of the Social Security Act, in which HCBS are furnished, and a copy of the standards applicable to each type of facility identified above are also maintained by the Medicaid Agency. These facilities will be used for the limited purpose of:_____
(Note: For example, respite care only when other services are unavailable.)

Financial Accountability - The State will maintain the financial integrity of the HCBS Waiver program. The State will assure financial accountability for funds expended for Home and Community-Based Services, provide for an independent audit of its waiver program, and will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. **See Appendix G-3**.

Evaluation of Need - The State will provide for an evaluation (and periodic reevaluations, at least annually) of the individuals' need for an institutional level of care, when there is a reasonable indication that individuals might need such services in the near future (one month or less) but for the availability of Home and Community-Based Services. The requirements for such evaluations and reevaluations are detailed in **Appendix D**.

Choice of Alternatives - When an individual is determined to require a level of care provided in a NF, hospital, or ICF/MR, the individual or his or her legal representative will be:

A. Informed of any feasible alternatives under the waiver; and
B. Given the choice of either institutional or Home and Community-Based Services.

The State will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care, or whose services are denied, suspended, reduced or terminated.

Average per capita expenditures - The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care, for which this waiver is an alternative, under the State plan that would have been made in that fiscal year had the waiver not been granted. Cost neutrality is demonstrated in **Appendix G**.

Actual total expenditures - The State's actual total expenditures for Home and Community-Based Services and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) for which this waiver is an alternative in the absence of the waiver. Cost neutrality is demonstrated in **Appendix G**.

Services absent the waiver - Absent the waiver, participants would receive the services appropriate to the level of care typically provided in institutional settings available through the State plan.

Reporting - The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the waiver and on the health and welfare of the persons served through the waiver. The information will be consistent with a data collection plan designed by CMS. Reporting is described in **Appendix F-2**

IV. Waivers Requested

Statewideness: The State requests a waiver of the "Statewideness" requirements set forth in Section 1902(a)(1) of the Act.

___**X**__ No. Services will be available Statewide.

_____Yes. Waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

_____

_____

Comparability: The State requests a waiver of the requirements contained in Section 1902(a)(10)(B) of the Act, to provide services to individuals served on the waiver that are not otherwise available to other individuals under the approved Medicaid State plan.

Income and Resources: The State requests a waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act in order to use institutional income and resource rules for the medically needy.

____**X**_____ Yes _____ No _____ N/A

V. State Specific Elements

A. Levels Of Care: This waiver is requested to provide Home and Community-Based Services (HCBS) to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan: (check all that apply)

_____ Hospital
_____ Nursing Facility
___**X**__ ICF/MR

B. Target Population: A waiver of Section 1902(a)(10)(B) of the Act is requested to limit Home and Community-Based Services waiver services to select groups of individuals who would be otherwise eligible for waiver services. The target groups are indicated below:

1. Target group per 42 CFR 441.301(b)(6) – Check all disability and age categories that apply. (**Note:** Current regulations governing 1915(c) waivers do not allow persons under age 65 with mental retardation or developmental disability – and no concurrent physical disability – to be served in a waiver that serves persons with physical disabilities only. Combining populations under the 1115 Demonstration authority is allowable.)

Category	**CHILDREN AGE RANGE**		**ADULTS AGE RANGE**		**AGED AGE RANGE**
	From	**To**	**From**	**To**	**From**
Aged only					
Disabled (Physical)					
Disabled (Other)					
Brain Injury (Acquired)					
Brain Injury (Trauma)					
HIV/AIDS					
Medically Fragile					
Technology Dependent					
Autism	**birth**	**21**			
Developmental Disability	**birth**	**21**			
Mental Retardation	**birth**	**21**			
Mental Illness					

2. States have the discretion to further define these target groups. If the State wishes to further define, please describe below:

In-home supports will be available to any child, adolescent or young adult under the age 21, who lives at home with his or her family and who:

(1) Is found to be eligible for services by an Area Agency pursuant to State rule He-M 503.05 for children/individuals ages 3 to 21 or pursuant to State rule He-M 510 for children/individuals under the age of 3.

(2) Is found to be eligible for Medicaid by the NH Department of Health and Human Services;

(3) Requires at least one of the following:

a. Services on a daily basis for:

1. Performance of basic living skills;

2. Intellectual, communicative, behavioral, physical/sensory motor and/or psychosocial/emotional development and well being;

3. Medication administration and instruction in, or supervision of, self-medication by a licensed medical professional; or

4. Medical monitoring or nursing care by a licensed professional person.

b. Services on a less than daily basis as part of a planned transition to more independence or to prevent circumstances that could necessitate more intrusive and costly services;

(4) Have a combination of 2 or more individual factors or a combination of 1 child/individual factor and 1 parent factor which complicate care of the child/individual or impede the ability of the care giving parent to provide care, including:

a. Child/individual factors of:

1. **Lack of age appropriate awareness of safety issues so that constant or intense supervision is required;**
2. **Destructive or injurious behavior to self or others;**
3. **Condition that significantly impedes the ability of the care-giving parent to provide care;**
4. **Inability to participate in local community childcare, or activity programs without support(s); or**
5. **Inconsistent sleeping patterns or sleeping less than 6 hours per night and requiring supervision when awake;**

b. Parent factors of:

1. **Age of either parent being less than 18 years or above 59;**
2. **Physical or mental health condition;**
3. **Developmental disability;**
4. **Substance addiction;**
5. **Care responsibilities for other family members with disabilities or severe health problems;**
6. **Founded child neglect or abuse; or**
7. **Availability of only one parent for care giving.**

3. The State selects the following option regarding individual cost limits:

___**X**___A. No otherwise eligible individual will be denied services or enrollment in the waiver solely because the cost of the individual's Home and Community-Based Services exceeds the average institutional Medicaid payment for the applicable level of care.

The State anticipates that it will need to approve some children/individuals for amounts higher than the average child/individual cost projected for this waiver. The State proposes a child/individual budget cap of $30,000 annually, so as to limit the need to offer more families lower funding amounts in order to accommodate a few higher cost plans.

_____ B. Otherwise eligible individuals may be denied home or community-based services if the agency reasonably expects that the cost of the Home and Community-Based Services would exceed the cost of an equivalent and applicable level of institutional care, pursuant to 42 CFR 441.301(a)(3). The State selects the following method to calculate these costs:

_____ **Individualized Computation.** The Medicaid cost of the individual's service plan is compared to the cost of serving *this particular individual* in the institutional setting.

_____ **Mathematical Average.** The Medicaid cost of the individual's service plan will be compared to the state's average per capita cost of applicable institutional care at _____ 100% of the institutional average or a level higher than 100% (_____%). Further, the limit will be calculated on the basis of:

_____ 1) Level of care
_____ 2) Diagnosis or condition

C. Medicaid Eligibility: All eligibility groups included under this waiver are covered in the State plan. The State will apply all applicable FFP limits under the plan.

1. ***Eligibility Criteria***: Specify whether your State uses the eligibility criteria used by the Supplemental Security Income (SSI) program or whether it uses more restrictive eligibility criteria than those of the SSI program for aged, blind, and disabled individuals: (check one):

____ SSI Criteria or 1634 State. The State uses SSI criteria.

___**X**_ 209(b) State. The State uses more restrictive eligibility criteria for aged blind, and disabled individuals than the criteria used under the SSI program.

2. ***Eligibility Groups Served*:** Individuals receiving services under this waiver are eligible for Medicaid under the following eligibility groups: (check one):

a. **X** All eligibility groups covered in the State plan are included under this waiver.

See C-25 for groups.

b. Only the following groups covered under the State plan are included under this waiver. (Check all that apply)

1. _____ Low-income families with children as described in Section 1931 of the Social Security Act
2. _____ SSI Recipients
3. _____Aged, blind or disabled who are eligible under 42 CFR 435.121
4. _____ Medically needy (A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act is requested to use institutional income and resource rules for the medically needy.)
5. _____ All other optional and mandatory groups under the plan except for those individuals who would be eligible for Medicaid only if they were in an institution).
6. _____ Individuals who would be eligible for Medicaid only if they were in an institution
7. _____ Individuals who would only be eligible for Medicaid, without spend down income, if they were living in a hospital, NF or ICF/MR. (Check one)

_____ All Individuals

_____ Limited to:

A special income level equal to:

_____300% of the SSI Federal Benefit Rate (FBR), OR

_____ %, a percentage lower than 300% of FBR, OR

$____, a specific amount that is lower than 300% of FBR

_____ Aged blind and disabled who meet requirements that are more restrictive than those in the SSI program

(Please explain:_____

_____

_____ Medically needy without spend down

_____ Other: _____

3. Spousal Impoverishment Protection: Spousal impoverishment rules may be used for determining eligibility for the special Home and Community-Based Waiver eligibility group at 42 CFR 435.217 for individuals who have a spouse residing in

the community. Further, these rules may apply to the post-eligibility treatment of income.

The State will use spousal impoverishment rules for determining income:
Yes **X** No

The State will use spousal impoverishment rules for the post-eligibility treatment of income:
_____ Yes ___**X**__ No

D. Services: The State requests that the following Home and Community-Based Services, as set forth in 42 CFR 440.180, be included under this waiver (Check all that apply here and define in **Appendix B**): (**NOTE:** All services must meet applicable regulatory standards and CMS policy guidance. Refer to **Appendix B** for new self-directed service descriptions.)

Check all that apply: **Note: There will only be one service, the Consolidated Developmental Service, authorized under this waiver. [Please see Appendix B for a definition of Consolidated Developmental Service.]**
The Consolidated Developmental Service will have the specific components indicated below. One or more of the components may be authorized for each child/individual based on his or her needs.

Service	Family or Individual Directed Method	Provider or Other Service Delivery Method
Case Management	**X**	**X**
Homemaker Services		
Home Health Aide Services		
Enhanced Personal Care Services (may include Attendant Care) **Note: Enhanced Personal Care is different from state plan personal care per 1905 (a) of the Social Security Act, as it includes additional items, such as training and transportation.**	**X**	**X**
Adult Day Health Services		
Habilitation Services		
Respite Services	**X**	**X**

Supports Brokerage Services/Functions (Required)	**X**	**X**
Fiscal/Employer Agent Services/Functions (Required)	**X**	**X**
Other (Describe in Appendix B) • **Environmental and Vehicle Mods.** • **Consultative Services** **Note: The above components will be embedded within the Consolidated Developmental Service, which will be the only service category authorized under the waiver.**	**X** **X**	**X** **X**

VI. Cost neutrality

The State has provided the supporting information/data to demonstrate cost neutrality in **Appendix G**.

VII. Additional Requirements

A. Plan Of Care: A written plan of care will be developed for each individual under this waiver utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and their family. The State's procedures governing the plan of care and the utilization of family or person-centered planning are included in **Appendix E**.

(**Note**: Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors.

The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training, supports, therapies, treatments and/or other services the individual is to receive to achieve those outcomes become a part of the plan of care.)

All services will be furnished pursuant to a written plan of care.

This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each.

The plan of care will address how potential emergency needs of the individual will be met.

The plan of care will be subject to the approval of the Medicaid Agency.

FFP will not be claimed for waiver services furnished prior to the development of the plan of care or services that are not included in the individual written plan of care.

B. Individual Budgets:

(**NOTE:** Individual budgets include the value of the waiver services available to the family or individual to support the individual's plan of care. Only waiver services as defined by the State are included in the individual budget. This amount of money designated in the budget is established by a methodology determined by the State and the amount is agreed upon with the family or individual.)

Check one:

_____ The State has established a uniform methodology by which all individual budgets in the State will be calculated. The methodology is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to CMS, and there is a process for re-determination.)

___**X**__ The State has established a minimum set of criteria and an approval process for methodologies developed by subcontractors, counties or other entities with which the State has contracted for the day-to-day operation of the waiver. The criteria by which individual budget methodologies will be reviewed and the approval process is described in **Appendix H**. (**Note**: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to, CMS, and there is a process for re-determination. Although the Medicaid Agency may contract with another agency or organization for the daily operation of the waiver program, it must retain the authority to issue policies, rules and regulations related to the waiver.)

C. Provider Selection: Families and individuals will have flexibility to select qualified providers of their choosing within the criteria established by the State. The criteria are described in **Appendix B.**

D. Plan Of Care Management: Families and individuals will have the ability to direct the services and supports identified in the plan of care within the resources available in the established individual budget. Families will have maximum possible flexibility in the utilization of resources delineated in the plan of care and individual budget. The State's description of how families may flexibly use resources while the State continues to assure health and welfare is described in **Appendix E**.

(Note: As determined by the state, families and individuals may have the ability to move resources among and between all or some of the services contained in the plan of care without a formal plan of care revision. Families or individuals might have full discretion to manage all of the plan or only parts of it. For example, the family or individual might manage the homemaker services, but not the habilitation services.)

E. Participant Protections: The State assures that each of the protections below is in place and described in **Appendix I**.

The State has procedures to assure that families have the requisite information and/or tools to participant in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation. Supports Brokerage and Fiscal/Employer Agent Services/Functions are required and should be provided by one or more entities. The services and the provider qualifications are described in **Appendix B**.

Upon family or individual request, the State makes available, at no cost, provider qualification checks, including criminal background checks. (Note: Provider qualifications for each service are described in **Appendix B**.)

The State has procedures to promote family and individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The State has a viable system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The State has procedures for how it will work with families or individuals and their fiscal/employer agents (if applicable) to monitor the ongoing expenditure of the individual budget.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

F. Quality Assurance & Improvement:

The State, through an organized quality assurance program, will provide appropriate oversight and monitoring of its HCBS Waiver program to ensure that each of the assurances contained in this application is met and to continually improve the operation of the program. The program will involve families or individuals in the process of assessing and improving quality. Details of this process are found in **Appendix F** of this request. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with their severity and nature and will contain an incident management system to address critical events.

G. Contact Person: The State Medicaid Agency Representative that CMS may contact with questions regarding the waiver request is:

Name: **Barbara Reed**

Title: **Program Specialist**

Agency : **NH Division of Developmental Services, Dept. of Health and Human Services**

Address: **105 Pleasant St., Main Bldg. Concord, N. H. 03301**

Telephone: **603-271-5027**

E-mail: **breed@dhhs.state.nh.us**

H. Authorizing Signature: This document, together with Appendices A through I, and all attachments, constitutes the State's request for a *Independence Plus:* A Demonstration Program for Family or Individual Directed Community Services Home and Community-Based Services Waiver under Section 1915(c) of the Social Security Act. The State affirms that it will abide by all conditions set forth in the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide Home and Community-Based Services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

(**Note:** The request must be signed by the Governor, Single State Agency or Medicaid Director, or a person within the State Medicaid Agency with the authority to sign on behalf of the State.)

Signature:
Print Name: **Kathleen G. Sgambati**
Title: **Acting Commissioner**
Date: **5/24/02-Original Submission Date-Signed by Donald Shumway, Commissioner**
8/1/02-Revised Submission Signature Date

APPENDIX A – DESCRIPTION OF THE WAIVER PROGRAM

(**Note:** The state must provide a narrative description of the waiver program beyond the general description above. This includes the intended purposes of the waiver.)

The State of New Hampshire's proposed In-Home Support Waiver for Children with Developmental Disabilities is intended to provide services and supports to children with developmental disabilities and their families. This waiver will emphasize family/individual choice, control and involvement in all aspects of services, as well as collaboration amongst staff and providers through the process of service planning and creation of individual/family service agreements and budgets. Ultimately, the waiver is intended to enable children to remain with their families and to participate in their communities.

The target population for the waiver is children/individuals who:

- **Have a developmental disability;**
- **Are between the ages of birth to 21;**
- **Qualify for New Hampshire's services under the State rules He-M 503 and He-M 510;**
- **Are Medicaid eligible;**
- **Meet the ICF/MR level of care requirement;**
- **Have a combination of child/individual and/or parental risk factors (described on pages C-6 and C-7); and**
- **Live with their families.**

The proposed waiver will be implemented within New Hampshire's regional developmental services system, which has been established as an Organized Health Care Delivery System, where 12 Area Agencies function as enrolled Medicaid Waiver providers. Because the Organized Health Care Delivery System model is used, the provider agreement is between the Medicaid Agency and the Area Agencies. Accordingly, the Area Agencies receive payment from the Medicaid Agency. The Area Agencies then pay the providers. New Hampshire will not pay cash directly to individuals/families.

The Area Agencies are nonprofit (501 C) entities and function as lead agencies within identified geographical regions regarding all aspects of developmental services. As such, the Area Agencies will have oversight responsibility for services provided under this waiver, including compliance with all applicable federal and state regulations. The Area Agencies are also the common law employer.

Area Agencies are governed by independent Boards of Directors, with 1/3 of their Board membership consisting of individuals with disabilities and family members. In addition the Area Agencies are advised by regional Family Support Councils. The State of New

Hampshire's deep-seated tradition of emphasis on "local control" is a prominent element of the system and provides a fitting and facilitating context for consumer directed services.

The proposed waiver will offer a single and unified service called Consolidated Developmental Service, which will consist of a range of home and community-based services intended to improve and maintain children's opportunities and experiences in living, socializing and recreating, personal growth, safety and health. The specific array of components within the Consolidated Developmental Service will include enhanced personal care, consultations, respite, environmental and vehicle modifications, family/support/service coordination (supports brokerage). [Fiscal intermediary services will be allowed under the proposed waiver and will be funded as part of the overall general administrative cost.] It is anticipated that the Consolidated Developmental Service approach will allow for greater flexibility in addressing the changing needs of children/individuals and their families and lead to more responsive, effective, and efficient delivery of services.

Families expressing an interest in receiving in-home supports through this waiver will apply through the local Area Agency for the geographical region in which they reside. Once a family expresses interest regarding in-home supports, but before services are delivered, the staff will explain to the family/individual the services, benefits and requirements of the waiver and discuss alternative service options regarding their specific need for in-home support services (Please see Appendix E for more details)

The families of children whose services are funded through this service category will have full freedom and control in choosing provider(s) for their services. [Note: Families will have the option of designating other family members and friends as providers. However, biological or stepparents of minor children will not be allowed to become providers for their children.] Under the proposed waiver, families will be able to choose along a spectrum of consumer directed services and agency managed services. If the family selects the managed option, the Area Agency will have ultimate responsibility for the service arrangement.

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In those cases where the family chooses to use a person or an entity not affiliated with the Area Agency to provide any aspect of services, the Area Agency will establish a contract with the entity, person or the family, addressing requirements and responsibility for the following:

- **Implementation of the individual service agreement;**
- **Specific qualifications, training and supervision required for the service providers;**
- **Oversight of the service provision, as required by the service agreement and applicable rules;**
- **Quality assessment and improvement activities as required by State rules and service agreement;**
- **Documentation of service provision and administrative activities;**

- **Compensation amounts and procedures for paying in-home support providers;**
  - **Intermediary services (such as preparing and disbursing payroll checks) provided by the Area Agency or subcontract agency;**
- **Compliance with applicable federal and state laws and regulations, including delegation of tasks by a nurse to unlicensed providers per NH RSA 326;**
- **Procedures for review and revision of the contract, as deemed necessary by any of the parties, and;**
- **Provision for any of the parties to dissolve the contract with notice.**

Regardless of the service delivery model chosen by the family, all service planning and provision will address issues concerning qualification and training of staff and providers, safety of the child/individual served and quality of services provided. Further, as described in Appendix E related to disputes regarding the service agreement, if a family selects a provider and the Area Agency determines that it will not enter into a service agreement with the selected provider, the dispute will be resolved through informal discussions between the family and the family support/service coordinator, by reconvening a service-planning meeting, or by the family filing an appeal to the Division of Developmental Services, pursuant to NH's Developmental Services Administrative Rule, He-M 503, Eligibility and the Process of Delivering Services.

Prior to the provision of in-home supports, the Area Agency will convene a service-planning meeting, to plan and prepare a written individual service agreement. [Please see Appendix E for more details.]

After the individual service agreement is established, specific components within the Consolidated Developmental Service will be costed out to construct an individualized budget. [Please see Appendix H for more details.] The proposed budget will be submitted to the Division of Developmental Services by the Area Agency for the necessary State approval.

Once the Division grants prior authorization for the proposed service arrangement, the Area Agency and/or subcontract agency will work closely with the family/individual to recruit, hire and train providers. The family/individual will be invited and supported to have a significant role in selection and training of providers. The degree of such consumer involvement will be based upon the particular interest level of the family/individual. [It is anticipated that some families/individuals will initially require more supports from the Area Agency and/or subcontract agency in getting involved in those aspects of their service arrangements.]

A high level of family/individual involvement will also be reflected in the way the Area Agency will track consumer satisfaction. Under the proposed waiver the family/individual will be provided with regular monthly opportunities to provide feedback to the Area Agency and subcontractor agency regarding their level of satisfaction with the services

received. This consistent and more frequent focus on soliciting information from the family/individual regarding quality will constitute one of the important ways the concept of consumer direction will be operationalized under the proposed waiver. It is anticipated that such an approach will enhance the chances for more effective communication between all of the parties involved in the service arrangement and thus increase the chances for successful outcomes for the individual/family.

In addition to monthly contacts regarding quality of services, there will also be communication between the Area Agency and the family/individual regarding the status of the individual budget. The Area Agency will provide the family/individual with a monthly report regarding the expenditures to-date and amount of funds still available from the authorized budget. Based on this monthly tracking and documentation of actual and projected expenses, the Area Agency family support/service coordinator will assist the family in managing the available funds. Through the individual planning process, the family will have the opportunity to request revisions and enhancements to their budget [Please see Appendix E]. The ultimate authorization of such revisions will lie with the Division of Developmental Services. [Note: The State believes that, in general, families themselves will be effective managers of their own authorized budgets by virtue of their relationship to the child/individual with the disability and their desire to maximize the supports that can be obtained under the authorized individual budgets.]

Those individuals and families receiving services under the proposed waiver will be afforded all of the personal and due process rights that have already been codified in New Hampshire's rules and regulations regarding the developmental services system [Please see State rules He-Ms 309, 310, 202, 203]. Regardless of the model of service delivery used, services will also be provided in ways that respect and protect personal rights. The emphasis on client rights will be reflected through ongoing training of providers and through vigorous implementation of a formal complaint process. The service system will also provide emergency response capacity as all of the Developmental Services System Area Agencies currently have 24-hour, 7-day-a-week emergency response capability. Moreover, both the Area Agencies and the New Hampshire Division of Developmental Services will conduct quality improvement surveys and activities as described in Appendix F.

Note: The Division of Developmental Services, in collaboration with departmental staff, contract agency staff, consumer advocates and family members, has drafted a proposed State rule (He-M 524) for this waiver program. [A copy of the draft is included with the supplemental documents.] The State will finalize this rule and submit it to CMS once the proposed waiver is approved.

APPENDIX B - SERVICE DEFINITIONS, STANDARDS AND PROVIDER QUALIFICATIONS

A. SERVICE DEFINITIONS, STANDARDS & PROVIDER QUALIFICATIONS CHARTS

For each service that was checked under State Specific Elements/Services of the template, the following chart must be completed. Each chart provides the State's service definition, outlines the provider qualifications and standards, and the service delivery method that govern the provision of each service under the waiver.

Provider qualifications would be expected to vary by the type of service being provided or managed. For those services for which there is a uniform State license or certification requirement, the legal citation is provided. For State defined standards other than those governed by State law, the standards are attached. Either the family or individual and the State Agency may manage some services. For example, the family or individual might have self-directed support services which include personal care type arrangements. The State may also have personal care services provided by an agency. The provider requirements might be different under these two arrangements. However, the differences must be explained.

For those services that are available in the State plan, the description must include those aspects of the service that go beyond the State plan coverage. (**Note:** For example, if personal care services are included in the State plan, personal care services provided under the scope of the waiver must differ in amount, scope, supervision arrangements or provider type **or** be utilized only when the state plan coverage is exhausted.)

The State has the authority to request that the Secretary approve "other" services identified by the State as cost neutral and appropriate to avoid institutionalization. Each "other" service defined by the State must be separately identified and defined and include the provider qualifications.

Service/Function Definitions Not Described Elsewhere:

> ***Supports Brokerage:*** Service/function that assists participating families and individuals to make informed decisions about what will work best for them, are consistent with their needs and reflect their individual circumstances. Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem solving. The service/function provides sufficient information to assure that participants and their families understand the

responsibilities involved with self-direction and assist in the development of an effective back-up and emergency plan. States may elect to fulfill the requirement of this service/function using a self-directed case manager or creating a distinct service. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. The services/functions included in Supports Brokerage are mandatory requirements of the template.

Fiscal/Employer Agent: Service/function that assists the family or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of the employment of service workers by the family or individual, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. This service/function, regardless of provider or method, must be delivered under a family or person-centered planning process and is a requirement of the template.

Other Services: Services appropriate to ensure the health and welfare of individual participants and, in conjunction with other services, serve as an alternative to institutionalization.

Service Title	**Consolidated Developmental Service**
Service Definition	**The Consolidated Developmental Service will consist of a range of home and community-based services intended to improve and maintain the child's/individual's opportunities and experiences in living, socializing and recreating, personal growth, safety and health. It is anticipated that this service will support the family as the primary caregiver of the child/individual. The specific array of services within the Consolidated Developmental Service include:** • **Enhanced Personal Care:** • **Consultations;** • **Respite;** • **Environmental and Vehicle Modifications;** • **Family Support/Service Coordination/(Supports Brokerage).** **One or more of the above components may be authorized for each child/individual based on his or her needs.**
Provider Requirements	**See individual service components below for provider requirements.**
State License	**See individual service components below for provider requirements.**

Certification	**See individual service components below for provider requirements.**
Other Requirements or Standards	**Providers must meet the requirements specified for each of the individual service components described below, and in addition, each applicant for employment must:** · **Meet the educational qualifications, or the equivalent combination of education and experience, identified in the job description;** · **Identify former employers and agree to 2 reference checks;** · **Meet certification and licensure requirements of the position, if any;** · **Present documentation of a TB test performed within the past year or undergo a TB test;** · **Agree to a criminal records check, prior to a final hiring decision, to ensure that the applicant has no history of a felony conviction; and** · **Be a minimum of eighteen years of age. However on an individual basis, upon agreement between the family and the Area Agency, persons as young as fifteen may be chosen as a provider.**
Describe Service Delivery Method (Agency or Self-directed)	**All components within the Consolidated Developmental Service are available along a spectrum, from agency managed to consumer directed depending on the choice of the family.** ❑ **When in-home supports are to be provided by a subcontract agency, the Area Agency shall establish a contract specifying the role of the Area Agency and subcontract agency in service planning, provision and oversight. The contract provisions will include, but are not limited to the following:** • **Implementation of the individual service agreement;** • **Specific training and supervision required for the service providers;** • **Compensation amounts and procedures for paying in-home support providers;** • **Oversight of the service provision, as required by the service agreement and applicable rules;** • **Documentation of administrative activities and service provision;** • **Intermediary services provided by the Area Agency or subcontract agency. "Intermediary services" means an array of fiscal and supportive services to facilitate the delivery of consumer-directed services, including:** ➢ **Computing tax withholdings;** ➢ **Filing and depositing employment taxes;** ➢ **Preparing and disbursing payroll checks;**

- **Collecting and verifying worker timesheets;**
- **Processing and paying non-labor related invoices;**
- **Processing criminal background checks on prospective workers; and**
- **Generating standardized reports depending on service design or fiscal arrangements.**

- **Family Support/Care Coordination (Supports Brokerage) including:**
  - **Coordinating, facilitating and monitoring services provided under the waiver;**
  - **Assessing and reassessing service needs;**
  - **Assistance with recruiting, screening, hiring, and training in-home support providers;**
  - **Identifying, providing information regarding and assisting families to access community resources and supports;**
  - **Development, review, and modification of service agreements;**
  - **Providing counseling and support;**
  - **Skills and advocacy training for the eligible consumer or representative;**
  - **Monitoring consumer satisfaction;**
  - **Initiating, collaborating and facilitating the development of a transition plan at the age of 16, to access adult supports, services, and community resources when the child//individual turns age 21, and**
  - **Creating and maintaining work registries;**

- **Quality assessment and improvement activities as required by rules and the service agreement;**
- **Compliance with applicable state laws and regulations, including delegation of tasks by a nurse to unlicensed providers per NH RSA 326.**
- **Procedures for review and revision of the contract as deemed necessary by any of the parties, and**
- **Provision for any of the parties to dissolve the contract with notice.**

- **When a family chooses in-home supports to be provided by an entity other than the Area Agency or subcontract agency, the Area Agency shall:**
  - **Discuss items specified above under Area Agency or subcontractor managed services with the family to enable the family to make an informed choice regarding the roles and responsibilities of the family, providers, and**
  - **Establish a contract with the family, which specifies the parties**

	responsible for the items listed above under Area Agency or subcontractor managed services.

Service Title	**Enhanced Personal Care component within the Consolidated Developmental Service**
Service Definition **Note: Enhanced Personal Care is different from the state plan personal care per 1905 (a) of the Social Security Act, as it includes additional items, such as training and transportation.**	**Enhanced Personal Care will assist an child/individual to continue living at home with his/her family and provide supports with:** • **Basic living skills such as eating, drinking, toileting, personal hygiene and dressing;** • **Improving and maintaining mobility and physical functioning;** • **Maintaining health and personal safety;** • **Carrying out household chores, and preparation of snacks and meals;** • **Communication, including use of assistive technology;** • **Learning to make choices, to show preferences, and to have opportunities for satisfying those interests;** • **Accessing and using transportation;** • **Developing and maintaining personal relationships;** • **Participation in community experiences and activities; and** • **Pursuing interests and enhancing competencies in play, pastimes and avocation.**
Provider Requirements	❑ **When a family chooses in-home supports to be provided by an Area Agency or subcontract agency, the Area Agency shall provide training, and support to the providers and document the providers' competency in areas, including:** • **Understanding and knowledge of the disability of the child/individual and of how the disability may effect the child's/individual's participation in everyday activities;** • **Using techniques specific to communicating with the child/individual and to carrying out specific activities of daily living including the use of adaptive equipment;** • **Supporting the child/individual to maintain and improve his/her quality of life in the family home and local community by promoting:** ➢ **The child's//individual's development of age-appropriate values family and social roles;** ➢ **The child's//individual's building of relationships with family, friends, and neighbors; and**

	➢ **Opportunities for the child//individual to participate in local community events and organizations;** • **Understanding challenging behaviors and facilitating more positive behaviors,** • **Using instructional techniques to assist learning;** • **Assuring basic health and safety practices;** • **Understanding and providing services in ways which support personal rights;** • **Understanding procedures necessary to ensure safe administration of medications if the child//individual is taking medication; and** • **Understanding and implementing the requirements of RSA 326 regarding delegation of tasks of client care by a licensed nurse to unlicensed persons.** ❑ **When a family chooses in-home support services to be provided by an entity other than the Area Agency or subcontract agency, the Area Agency shall:** • **Discuss items specified under provider requirements above, with the family; and** • **Establish a contract with the family specifying responsibility for training to assure providers' competencies in the above areas and provision of support to the in home providers.**
State License	**If the family chooses a Certified Nursing Assistance, Licensed Practical Nurse, or Registered Nurse, that provider would need to be licensed or certified under the State's Nurse Practice Act, NH RSA 326. If the family selects providers who are delivering services under a practice act, they would need to comply with the State's licensure and certification under the appropriate law. Other providers will not need state licensure or certification, but will require the training listed above.**
Certification	
Other Requirements or Standards	**See Consolidated Developmental Service above.**
Describe Service Delivery Method (Agency or Self-directed)	**See Consolidated Developmental Service above.**
Service Title	**Consultations component within the Consolidated Developmental Service**
Service	**Consultations include:**

Definition	• **Evaluation, training, mentoring, and special instruction, which maximize the ability of the service provider, family and other caregivers of a specific child//individual to understand and care for that child's//individual's developmental, functional, health and behavioral needs, and** • **Support and counseling for families for whom the day-to-day responsibilities have become overwhelming and stressful to the family.**
Provider Requirements	**See Consolidated Developmental Service above.**
State License	**If a family chooses a psychologist, psychiatrist or other consulting health care professionals requiring licensure under state law to practice, they would need to have the appropriate licensure and/or certification required under state law. Other providers will not need state licensure or certification, but will require the training listed under provider requirements above.**
Certification	
Other Requirements or Standards	**See Consolidated Developmental Service above.**
Describe Service Delivery Method (Agency or Self-directed)	**Both agency managed and self directed depending on needs and desires of the family. See Consolidated Developmental Service above.**
Service Title	**Respite component within the Consolidated Developmental Service**
Service Definition	**Respite care services consist of the provision of short-term assistance, in or out of an eligible child's/individual's home, for the temporary relief and support of the family with whom the child/individual lives.**
Provider Requirements	❑ **The following criteria shall apply to Area Agency arranged respite care providers:** • **Providers shall be able to meet the day-to-day requirements of the child/individual served, including:** ➢ **Activities normally engaged in by the child/individual; and** ➢ **Any special health, physical and communication needs.** • **The Area Agency will arrange for training of respite care providers in the following areas:** ➢ **The value and importance of respite care to a family;** ➢ **Mission statement;** ➢ **Emergency first aid;** ➢ **The nature of developmental disabilities;** ➢ **Behavior management; and**

	➢ **Communicable diseases.** • **Other specialized skills may be required of the provider, as determined by the Area Agency in consultation with the family in need of respite care.** • **Training identified above shall be required unless the provider's experience or education has included such training or the respite care provider has, in the judgment of the Area Agency and the family, sufficient skills to provide respite care for a specific person.** • **Medication administration shall be in compliance with applicable state laws and regulations, including delegation of tasks by a nurse to unlicensed providers per NH RSA 326.** • **Respite care providers giving care in their own homes shall serve no more than 2 persons at one time.** • **If respite care is provided overnight, respite care providers shall have a responsible person to contact who, in the judgment of the provider, is able to assist in providing care to an child/individual in the event that the provider is unable to meet the respite needs of the child/individual or comply with state's respite rules.** • **Liability insurance shall be maintained and documented as follows:** ➢ **Providers providing respite care in their own homes shall maintain liability insurance coverage within their homeowners' or tenants' insurance policies;** ➢ **Providers who will be transporting children/individuals in their own automobiles shall so inform the family or guardian and shall carry automobile liability insurance;** ➢ **Providers shall send written proof of required liability insurance to the Area Agency; and** ➢ **The Area Agency shall carry liability insurance to cover potential liabilities in the provision of respite care related services.** ▫ **The following criteria shall apply to family arranged respite:** · **Any family or individual determined to be eligible and approved by the Area Agency to receive respite care may make its own arrangements for respite care through the use of extended family, neighbors, or other people known to the family.** ➢ **In circumstances where the family arranges for respite care, all arrangements shall be at the discretion of, and be the responsibility of, the family except as noted below.** ➢ **The Area Agency shall establish, and inform the family of, compensation amounts and procedures for family arranged respite care.** ➢ **If respite care is to be provided in a residence certified by the state, the provider shall be trained in medication administration in compliance with the State's Nurse Practice Act, NH RSA 326.**

State License	**If a family chooses a Certified Nursing Assistance, Licensed Practical Nurse, or Registered Nurse, that provider would need to be licensed or certified under the State's Nurse Practice Act. RSA 326. If the family selects providers who are practicing under a practice act, they would need to comply with the State's licensure and certification under the appropriate law. Other providers will not need state licensure or certification, but only the training listed above.**
Certification	
Other Requirements or Standards	**See Consolidated Developmental Service above.**
Describe Service Delivery Method (Agency or Self-directed)	**See Consolidated Developmental Service above.**
Service Title	**Environmental and Vehicle Modifications component within the Consolidated Developmental Service**
Service Definition	**Environmental and vehicle modifications consist of adaptations to the home environment to ensure access, health and safety, or consist of adaptations to vehicles to ensure the child's/individual's safety and access to the community. Examples include ramps, lifts, handrails, widening doorways etc.**
Provider Requirements	**Requirements for professionals creating environmental and vehicle modifications will vary depending on the task.**
State License	
Certification	
Other Requirements or Standards	**Local and state licensure for contractors, as appropriate.**
Describe Service Delivery Method (Agency or Self-directed)	**See Consolidated Developmental Service above.**
Service Title	**Family Support/Service Coordination (Supports Brokerage) component within the Consolidated Developmental Service**
Service Definition	**Family Support/Service Coordination (Supports Brokerage) component includes the following:** • **Coordinating, facilitating and monitoring services provided under the waiver;**

	· **Assessing and reassessing service needs;** · **Assistance with recruiting, screening, hiring, and training in-home support providers;** · **Identifying, providing information regarding and assisting families to access community resources and supports;** · **Development, review, and modification of service agreements;** • **Providing counseling and support;** · **Skills and advocacy training for the child/individual or representative;** · **Monitoring consumer satisfaction;** • **Initiating, collaborating and facilitating the development of a transition plan at the age of 16, to access adult supports, services, and community resources when the child/individual turns age 21; and** • **Creating and maintaining work registries.**
Provider Requirements	**Family Support/Service Coordinators (Supports Brokers) must meet the following requirements:** • **Have demonstrated competencies to provide family support/service coordination (service brokerage) described above;** • **Possess the ability and commitment to work collaboratively with all team members; and** • **Possess knowledge of community resources, services and supports.**
State License	
Certification	
Other Requirements or Standards	**See Consolidated Developmental Service above.**
Describe Service Delivery Method (Agency or Self-directed)	**See Consolidated Developmental Service above.**

B. ASSURANCES THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.
2.
3. The State assures that each service furnished under the waiver is cost-effective (compared to the cost of institutional care) and necessary to prevent institutionalization. Cost effectiveness is demonstrated in **Appendix G.**

C. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX C-Eligibility and Post-Eligibility
SECTION 1915(c) WAIVER FORMAT

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. **X** Low income families with children as described in section 1931 of the Social Security Act.

2. SSI recipients (SSI Criteria States and 1634 States).

3. **X** Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. **X** Optional State supplement recipients

5. Optional categorically needy aged and disabled who have income at (Check one):

   a. 100% of the Federal poverty level (FPL)

   b. % Percent of FPL which is lower than 100%.

6. **X** The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

A. Yes **X** B. No

Check one:

a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. **X** Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) **X** A special income level equal to:

300% of the SSI Federal benefit (FBR)

% of FBR, which is lower than 300% (42 CFR 435.236)

$ **1250** which is lower than 300%.

(2) **X** Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) **X** Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) Aged and disabled who have income at:

a. 100% of the FPL

b. % which is lower than 100%.

(6) Other (Include statutory reference only to reflect additional groups included under the State plan.)

_____

7. **X** Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. **X** Other-**All other groups covered under the NH Medicaid State Plan.**

Note: Individuals must also meet all other eligibility criteria as specified under Section V. B. Target Group on page C-7.

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) The special income level for the institutionalized

(4) The following percent of the Federal poverty level): %

(5) Other (specify):

B. The following dollar amount:
$ *

* If this amount changes, this item will be revised.

C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A. SSI standard

B. Optional State supplement standard

C. Medically needy income standard

D. The following dollar amount:
$ *

* If this amount changes, this item will be revised.

E. The following percentage of the following standard that is not greater than the standards above: % of standard.

F. The amount is determined using the following formula:

G. Not applicable (N/A)

3. Family (check one):

A. AFDC need standard

B. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. The following dollar amount:
$ *

*If this amount changes, this item will be revised.

D. The following percentage of the following standard that is not greater than the standards above: % of standard.

E. The amount is determined using the following formula:

F. Other

G. Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) **X 209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. **X** The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) **X** The special income level for the institutionalized

(4) The following percentage of the Federal poverty level: %

(5) __Other (specify):

B. The following dollar amount:
*_____

* If this amount changes, this item will be revised.

C. __ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A. The following standard under 42 CFR 435.121:

B. The medically needy income standard;

C. The following dollar amount:
$ *

* If this amount changes, this item will be revised.

D. The following percentage of the following standard that is not greater than the standards above: % of

E. The following formula is used to determine the amount:

F. **X** Not applicable (N/A)

3. family (check one):

A. AFDC need standard

B. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. The following dollar amount:
$ ____*

* If this amount changes, this item will be revised.

D. The following percentage of the following standard that is not greater than the standards above: % of standard.

E. The following formula is used to determine the amount:

F. Other

G. **X** Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a) SSI Standard

(b) Medically Needy Standard

(c) The special income level for the institutionalized

(d) The following percent of the Federal poverty level: %

(e) The following dollar amount
$ **

**If this amount changes, this item will be revised.

(f) The following formula is used to determine the needs allowance:

(g) Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

Persons performing initial evaluations of level of care for waiver applicants will have the following educational/professional qualifications:
Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

b. PROCESS FOR LEVEL OF CARE DETERMINATION
The following describes the process for evaluating and screening waiver applicants to determine level of care:

The Area Agency will forward the child's/individual's service agreement, New Hampshire's Forms 276 A (completed by a physician or nurse) and B (completed by the family support/service coordinator), which document information related to the diagnoses, needs, disabilities and risk factors for the child/individual to the Division of Developmental Services. The Division of Developmental Services' QRMP will review these documents, along with any other available information, such as results of assessments, to determine the child's/individual's eligibility for the waiver. Determinations will be reviewed every 12 months. For re-determinations, the Area Agency will send New Hampshire's Form 277 (completed by the family support/service coordinator) to the Division.

c. CONSISTENCY WITH INSTITUTIONAL LEVEL OF CARE
The State will use the following methods to ensure that level of care determinations used for the waiver program are consistent with those made for institutional care under the State plan:

The following definition for ICF/MR level of care is in the State plan and will be used for this waiver.
A child/individual requires ICF/MR level of care if he/she requires, on a daily basis, services for at least one of the following:

- ❑**Performance of basic living skills;**
- ❑**Intellectual, physical/sensorimotor and/or psychological/emotional development and well-being;**
- ❑ **Medication administration and instruction in, or supervision of, self-medication by a licensed medical professional; or**
- ❑**Medical monitoring or nursing care by a licensed professional person.**

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at least annually) according to the following schedule:

Every 12 months.

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Persons performing reevaluations of level of care will have the following qualifications:

The educational/professional qualifications of person(s) performing reevaluations of level-of-care are the same as those for persons performing initial evaluations.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care:
A computerized system, Prior Authorization Waiver System, (PAWS) is already operational for the adult DD and ABD waivers and this system will be simply modified to support the proposed children's waiver. The automated system will identify authorizations that are expiring as of a certain date. Prior authorizations are also entered on the MMIS, which is employed by EDS (the fiscal intermediary for NH's general Medicaid program) and supports payment of Medicaid claims. The edits under the current MMIS do not allow payments for claims dated beyond the expiration date of the prior authorization.

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APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s):
   Division of Developmental Services

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.
   Division of Developmental Services

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. If this instrument differs from the form used to evaluate or assess institutional

level of care, a description of how and why it differs and an assurance that the outcome of the determination is reliable, valid, and fully comparable is attached.

Please see the attached Forms 276 A and B (for initial evaluation) and Form 277 (for reevaluation)

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care provided in an institutional setting, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or Home and Community-Based services.

PROCESS: The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

Prior to the provision of services, the Area Agency will convene a meeting during which the family will be informed of service options available through this waiver, as well as the choices under the Medicaid State Plan services, including institutional settings, community resources and other alternatives that might be pertinent to the child's/individual's and family's specific situation. The child/individual, when age appropriate, and the family will be informed that the service options offered can be accessed on a voluntary basis.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

PROCESS: The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:

Upon determination of eligibility, the Area Agency will convey to each applicant or guardian a written decision on eligibility. In each instance when eligibility is denied, information on the reason for denial, the right to appeal, and the process for appealing the decision will be provided, including the names, addresses, and telephone numbers of the Office of Client and Legal Services Unit of the Division and advocacy organizations which the individual or guardian may contact for assistance in appealing the decision. (See service agreement approval form attached.)

Any Medicaid recipient who has been denied waiver services because he/she does not meet the eligibility criteria may appeal the decision by requesting a fair hearing.

If a fair hearing is requested, the following actions will occur:

- **For current recipients, services and payments will be continued as a consequence of an appeal for a fair hearing until a decision has been made; and**
- **If the Division of Developmental Services' decision is upheld, benefits will cease 60 days from the date of the denial letter or 30 days from the hearing decision, whichever is later.**

In every case of denial of a request for prior authorization of services, the Area Agency will notify the individual/guardian.

b. FREEDOM OF CHOICE DOCUMENTATION

The concept of freedom of choice for all services provided in the developmental services system is codified in New Hampshire's state rule He-M 503 as follows:
"All services shall:

- **Be voluntary;**
- **Be provided only after the informed consent of the individual/family;**
- **Comply with the rights of the child/individual established under NH law RSA 171-A:14 and rules adopted thereunder; and**
- **Facilitate as much as possible the individual's/family's ability to determine and direct the services it will receive."**

1. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix.

The State will not require the Area Agencies to use a specific form and will accept the approval/disapproval page of the individual service agreement as documentation of freedom of choice. [Sample service agreement approval/disapproval forms are attached.]

As stated above, prior to approving the service agreement, the child/individual/guardian and family will be fully informed of community and institutional service alternatives and of their rights to a fair hearing if they are not in agreement with components of the service agreement. If a situation were to arise in which a family did want to seek an institutional placement for their family member, the Area Agency would assist the family in seeking such a setting.

2. Copies of free choice documentation are maintained in the following location(s):

Area Agencies and Division of Developmental Services.

APPENDIX E - PLAN OF CARE

APPENDIX E-1 - PLAN OF CARE DEVELOPMENT/MAINTENANCE

a. The attached policy and procedures define and guide the family or person-centered planning process and assure that families are integrally involved in the plan development and that the plan of care reflects their preferences, choices, and desired outcomes.

Under New Hampshire's In-Home Supports Waiver for Children with Developmental Disabilities, individual and family involvement, and consumer choice and control will be the guiding principles for the development and maintenance of the service agreements (i.e. plans of care). Accordingly, the service planning under the waiver will be a personalized and ongoing process to plan, develop, review, and evaluate the services in accordance with the preferences and desired outcomes of the family/child/individual. The family/child/individual will be afforded the opportunity to identify those services and environments that will promote the child's/individual's health, welfare, and quality of life.

The family support/service coordinator will maximize the extent to which a family/ individual participates in the service planning process by:

- **Explaining to the family/individual the service planning process;**
- **Eliciting information from the family/individual regarding their preferences, goals, and service needs that will be a focus of service planning meetings; and**
- **Reviewing with the family/individual issues to be discussed during service planning meetings.**

Each family/individual will be invited and assisted to determine the following elements of the service planning process:

- **The number and length of meetings;**
- **The location and time of meetings;**
- **The meeting participants; and**
- **Topics to be discussed.**

Prior to the provision of in-home supports, the Area Agency will convene a service-planning meeting for each family/individual and prepare a written individualized service agreement, which will be jointly developed by the family/individual, providers, consultants, family support/service coordinator and other persons involved in the life of the child/individual. Additional service planning meetings will occur within 6 months of the initial meeting and not less than annually thereafter.

The family/individual will have the authority to initiate a service-planning meeting when a service agreement is not being carried out in accordance with its terms, when a change to another service is desired, or when a crisis has developed for the family/individual.

Within 14 days following a service planning meeting the family support/service coordinator will prepare a written service agreement that will describe the individualized supports to

be provided including: a list of specific activities to be carried out; the specific schedule for provision of services; the person(s) responsible for providing the supports; and specific documentation requirements. The family support/service coordinator will also insure that the service agreement describes how in-home supports will be delivered in collaboration with other related support plans when applicable, such as an child's/individual's education plan or a behavioral plan; and be consistent with other services provided in all additional environments, such as community and school.

Within the planning process of the waiver, service agreements may be changed at any time by the family/individual, providers, family support/service coordinator, and others involved in the care of the child/individual through joint discussion, written revision, and consent as shown by signature of the parent/guardian. The service agreements will be reviewed as requested or at least annually with formal discussion of the child's/individual's progress and the family's/individual's satisfaction, and will be revised in accordance with the child's/individual's interests and needs and the family's priorities.

If either the family or Area Agency director disapproves of the service agreement, the dispute shall be resolved through informal discussions between the family and family support/service coordinator, by reconvening a service-planning meeting, or by the family filing an appeal to the Division of Developmental Services.

2. The following individuals are responsible for the preparation of the plans of care:

After the joint development of the service plan, the family support/service coordinator will typically be responsible for documentation of the individualized service agreement. The service coordinator will be chosen or approved by the family/individual and designated by the Area Agency. If the family/individual selects a service coordinator who is not employed by the Area Agency or its subcontractor, the service coordinator and Area Agency will enter into an agreement, which describes:

- **The specific responsibilities of the service coordinator;**
- **The reimbursement to the service coordinator; and**
- **The oversight activities to be provided by the Area Agency.**

Overall, family support/service coordinators are responsible for the following:

- **Coordinating, facilitating and monitoring of services provided under the waiver;**
- **Assessing and reassessing service needs;**
- **Assistance with recruiting, screening, hiring, and training in-home support providers;**
- **Development, review, and modification of service agreements;**
- **Providing counseling and support;**
- **Skills and advocacy training for the eligible consumer or representative;**
- **Monitoring consumer satisfaction;**
- **Initiating, collaborating and facilitating the development of a transition plan at the age of 16, to access adult supports, services, and community resources when the child/individual turns age 21; and**
- **Creating and maintaining work registries.**

Copies of written plans of care will be maintained for a minimum period of 3 years in the following location(s):

The Area Agency with the primary authority for the child's/individuals' services.

The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability, and responsive to the individual's needs and preferences. The minimum schedule under which these reviews will occur is:

Under the proposed waiver, individual service agreements will be reviewed at least annually with formal discussions about the child's/individual's progress and the family's satisfaction, and will be revised in accordance with the child's/individual's needs and interests and the family's priorities. The plans may be reviewed more often based on the preferences of the family/individual and modified at any time by the family/individual, service providers, family support/service coordinator, and others involved in the care of the child/individual through joint discussion, written revision, and consent as shown by signature of the parent/guardian.

5. If the State uses a standardized plan of care document, a copy of this form should be submitted.

APPENDIX E-2 – MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency.
The Division of Developmental Services will determine the need for services based on the criteria specified in Appendix D, which includes submission of the proposed service agreement.

APPENDIX E-3 – PLAN OF CARE MANAGEMENT

The following is a description of process and parameters within which families or individuals have flexibility to utilize resources identified within the plan of care and the individual budget that do not necessitate a formal revision to the plan of care. In addition, the State's infrastructure to support families or individuals in directing and managing their plan of care is described here.

Through the proposed service category of Consolidated Developmental Service, the State of New Hampshire seeks to provide families/individuals with full flexibility to exercise choice and control in utilizing and managing the resources authorized under this waiver. Accordingly, subsequent to the creation of an individualized service agreement (identifying the specific service components to be provided) and a budget (projecting the cost of each service element) the family/individual will be able to direct the Area Agency to transfer monies from one line item of their budget to another. As long as such proposed transfers are within the limits of the total authorized funds, they will not require additional reviews or approvals from the Division of Developmental Services.
[For example, a family who decides to receive additional hours of services from a behavioral consultant will be able to direct transfer of funds from their respite line-item to the consultation line-item without seeking a formal change in their prior authorization from the State, or, if the family wishes to switch from one consultant to another, again they will be able to do so without formal revisions to the prior authorization.]

Each instance of realignment and management of resources by the family/individual will be carried out in collaboration with the local Area Agency to insure that the family/individual will receive information and assistance in making such decisions and that the proposed changes will be consistent with the intent of the individualized service agreement and the authorized budget. In such cases, the family support/service coordinator and other staff from the Area Agency will serve as a resource to the family in achieving the desired service outcomes.

APPENDIX F – QUALITY ASSURANCE AND IMPROVEMENT

APPENDIX F-1 - QUALITY ASSURANCE & IMPROVEMENT PROGRAM

A description of the State's quality assurance and improvement program is attached. This description includes State policies and procedures which describe the:

1) frequency of quality assurance activities;
2) domains/dimensions/assurances that will be monitored (e.g., access, person-centered service planning, provider capacity and capabilities, participant safeguards, participant rights, participant outcomes and satisfaction, etc.);
3) process of discovery (including sampling methodologies and whether or not information is collected from interviews with families/individuals in their community residences);
4) identification of the persons responsible for conducting quality assurance activities and their qualifications (including how families and individuals will be involved in the process of assessing and improving quality);
5) provisions for periodically reviewing and revising its quality assurance policies and procedures when necessary;
6) provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies and
7) system to receive, review and act upon critical events or incidents.

New Hampshire's developmental services system has established multiple processes to review and improve the quality of services being provided through its 12 Area Agencies and to insure personal rights, health and safety of the children/individuals receiving services. Within the framework of "Quality is everybody's business!" a variety of stakeholders (Board of Directors and management team, and subcontract agency staff and providers, Division of Developmental Services staff, and consumers and their families) are expected to play a role in the continuous quality improvement of services. The following is a listing of those systemic elements and procedures that are currently in place:

- **On at least a monthly basis the Area Agency family support/service coordinator or designated staff will visit or have verbal contact with the family/individual or providers responsible for direct provision of services and document the visit or contact. Moreover, the Area Agency will provide the family/individual with a monthly feedback form, which the family/individual will use to document their level of satisfaction and to identify any issues or concerns regarding services delivered.**
- **At least quarterly, or more frequently if so specified in the child's/individual's service agreement, the family support/service coordinator or designated staff will visit or have verbal contact with the family/individual to determine and document whether the services:**
  - **Match the interests, needs, competencies and lifestyle of the eligible child/individual;**
  - **Meet the child's/individual's environmental and personal safety needs;**
  - **Comply the terms of the service agreement; and**

- **Meet the individual's/family's satisfaction with services.**

- ❑ **Each year the Division of Developmental Services staff will interview about 10% of the families/individuals receiving services under this waiver to determine their level of satisfaction with the services being provided. After completion of the interview, an individual report will be written and shared with the family/individual and family support/service coordinator, describing the results of the interview. This report will serve as a means to bring attention to those areas where improvements are needed, and the family support/service coordinators will have the responsibility to follow up on the issues identified. Moreover, individual reports will be compiled into 12 regional reports to recognize the regional accomplishments and identify areas needing improvement. These regional reports will be used by the Area Agencies to address local issues and achieve continuous quality improvement. Lastly, the Division will incorporate the regional summaries into a statewide report to initiate continuous quality improvement efforts, such as providing trainings, modifying state policies and regulations.**
- ❑ **The Division will also include the In-Home Support Waiver program in its area agency redesignation reviews, which will be conducted every five years. Redesignation of Area Agencies is a very comprehensive review process through which Area Agencies are evaluated regarding their performance with respect to the following indicators:**
  - **Rights, health and safety;**
  - **Choice, control and satisfaction;**
  - **Mission;**
  - **Individual and family/guardian involvement;**
  - **System of quality improvement;**
  - **Governance and administration;**
  - **Budget development and fiscal health; and**
  - **Compliance (with federal and state rules).**

  As part of the redesignation process, the Division holds consumer and family forums where those receiving services have the opportunity to comment on the Area Agency's performance with respect to quality of services, personal rights, health and safety. In addition, the Division staff members review the Area Agencies' policies and activities regarding quality improvement, consumer choice, control and satisfaction, and consumer rights, health and safety, and provide feedback to the agencies regarding how the regional system may be further improved with respect to these areas. At the end of the redesignation process, the Division produces a summary report, documenting its findings regarding all aspects of Area Agency operations and its recommendations as to how to improve them. The Area Agencies' Boards of Directors and management teams are expected to use the contents of these reports for future planning and continuous quality improvement purposes.

As part of the its focus on quality of services, the state of New Hampshire has put in place the following systemic elements regarding consumer rights:

- ❑ **The State has established rules (He-M 309, 310, 202, 203) to insure protection of personal rights, due process and investigation and resolving of complaints.**
- ❑ **As a part of the annual individual planning process, the Area Agency family support/service coordinator provides information to the individual/family regarding personal rights and the complaint process.**

- **Each provider, staff member and volunteer who is asked to provide supports within the system is given ongoing training regarding consumer rights and the complaint process.**
- **The providers and staff are also required to complete accident and incident reports and share them with family support/service coordinators and Area Agency administration. These reports are used to address individual circumstances, as well as to improve regional service systems.**
- **New Hampshire's laws and regulations require employees and providers of the Area Agency or subcontract agency to promptly make a complaint to the Area Agency's regional complaint investigator on behalf of a child/individual whenever they have reason to believe that a child/individual has been subjected to abuse, neglect or exploitation. In addition, the staff and providers must report an instance of abuse, neglect or exploitation of a child/individual to New Hampshire' Division of Elderly and Adult services (DEAS) or Division for Children, Youth and Families (DCYF). Both of these reporting requirements lead to two separate investigations and reports, which maximize the opportunities for resolution of the issues identified. The Area Agencies are required to follow up on the recommendations of these reports and take all of the necessary steps to correct the current conditions and prevent future occurrences. The Area Agencies are also required to notify the Division of Developmental Services' Office of Client and Legal Services of all complaints filed, investigations carried out and ensuing actions taken.**
- **Employees and providers are also expected to assist persons who wish to file a complaint to contact the complaint investigator or obtain services from advocacy agencies.**
- **Each Area Agency has one or more persons designated as complaint investigators who are expected to investigate and attempt to resolve the complaint to the satisfaction of the individual or his or her guardian within 15 working days.**
  - **The complaint investigator interviews the complainant; the individual; the guardian, if any; the respondent; any witnesses to any incident on which the complaint is based; and any clinical consultant whom the investigator utilizes to assist with the investigation; and reviews information in the child's/individual's record, policies and procedures, and any other documents that have been determined by the investigator to be relevant.**
  - **The complaint investigator prepares a report which includes a summary of the issues presented; the names of persons interviewed during the investigation; a summary of the investigatory findings of fact, a proposed determination of whether the allegations are founded or unfounded, and an explanation of why such determination was made; the dates of any reports made to DEAS or DCYF; a list of all documents reviewed; and the proposed resolution.**
  - **The report is forwarded to the individual or his or her guardian. If the individual or his or her guardian does not accept the proposed determination or proposed resolution, he or she may ask for further investigation.**

- **In addition to the above processes, New Hampshire's regulations provide the Commissioner of Department of Health and Human Services or his/her designee the authority to investigate any complaint concerning conditions which pose an imminent risk to the health or safety of individuals.**

- **Each Area Agency has a human rights committee to review and oversee issues related to personal rights, complaint investigations, and behavioral supports. The membership for this committee usually includes family and Board members, representatives of the community, as well as staff and providers. The committee reviews individual behavioral proposals and receives summaries regarding incidents/accidents and complaint investigations and makes recommendations to foster and promote the rights, health and safety of children/individuals served.**

- **The Division has established a statewide Medication Committee to review and oversee issues related to medication administration and health. The membership of this committee includes a physician, representative from the Board of Nursing, and Division and regional nurses. The committee receives reports of medication errors from the Area Agencies twice a year and makes recommendations to the m regarding improvements related to medication administration.**

APPENDIX F-2 ANNUAL REPORTS

A summary of the results of the State's monitoring of recipient health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

Along with its annual HCFA 372 report, the state of New Hampshire will submit its In-Home Support Waiver outcome report, which will contain the results of its interviews with families/individuals receiving services under the proposed waiver. [Please see Appendix F for more information regarding these interviews and the report.]

APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW AND DEMONSTRATION OF COST NEUTRALITY FORMULA

LEVEL OF CARE:
_____**ICF/MR**_____
Definitions:

(NOTE: A separate chart should be filled out for every level of care in the waiver program. The State should also include a chart reflecting the weighted average of the combined levels of care offered in the program.)

Using previous years' MMIS paid claims data for Medicaid services, such as home health aides, respite care, early intervention (Part C of IDEA), and Medicaid to schools services, the state of New Hampshire has identified approximately 200 children with significant long-term care needs who have diagnoses indicative of eligibility for ICF/MR level of care. Using costs associated with supporting children with these needs in non-institutional settings, such as cost of home health services, respite care, supplies and equipment etc., the State projected average annual costs for individualized budgets for these children and their families.

Factor D Estimated annual average per capita Medicaid cost for Home and Community-Based Services for individuals in the waiver program.

Factor D' Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program

Factor G Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.

Factor G' Estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G ?	Col. 8 Difference (subtract column 4 from column 7)
1	**$19,847**	**$27,922 (1)**	**$47,769**	**$91,280**	**$9,904 (3)**	**$101,154**	**$53,385**
2	**$19,861**	**$28,480 (2)**	**$48,341**	**$93,075**	**$10,102 (2)**	**$103,177**	**$54,836**

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G ?	Col. 8 Difference (subtract column 4 from column 7)
3	**$20,442**	**$29,050 (2)**	**$49,492**	**$94,937**	**$10,304 (2)**	**$105,241**	**$55,749**
4							
5							

Notes: (1) MMIS Paid Claims
(2) Projected 2% increase over previous year.
(3) HCFA 372 report for 9/1/99-8/31/00 for ICF/MR

If states elect to consider Supports Brokerage and/or Fiscal/Employer Agent Services/Functions administratively rather than as wavier services, these costs and the methodology used to calculate the costs must be identified.
Included in components of the Consolidated Developmental Service.

Service	Estimated Costs	Methodology Description
Fiscal/Employer Agent	**Individualized**	**Costs related to Fiscal Agents will be included in the overall administrative cost, which will be calculated as 12% of the service/programmatic costs for each individualized budget.**

APPENDIX G-2 - DERIVATION OF ESTIMATES

NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS	EXPLANATION of ESTIMATE of NUMBER of UNDUPLICATED INDIVIDUALS SERVED:
1	**180**	**Using previous years' MMIS paid claims data for Medicaid services, such as home health aides, respite care, early intervention (Part C of IDEA), and Medicaid to schools services, the state of New Hampshire has identified approximately 200 children with significant long-term care needs who have diagnoses indicative of eligibility for ICF/MR level of care.**
2	**190**	
3	**200**	
4		
5		

FACTOR D: AVERAGE COST OF WAIVER SERVICES The data that are included in the below table are based on projections only, since each individual budget will be constructed to meet the specific family's/individual's needs and utilization of components will change as the family's/individual's situation changes.

For HCFA 372 reporting purposes NH will provide the following information: Through an unique procedure code NH's MMIS will track the total number of people served and amount of funds used under the Consolidated Developmental Service category. Based on individual service agreements and budgets, the global data will be further broken down to specific components i. e. personal care, respite, etc. The Consolidated Developmental Service is made up of the following components. The units per user and cost data are based on projections only, since each individual budget will be constructed to meet the specific family's needs and utilization of components will change as the family's situation changes.

Year 1				
Waiver Service (Add row for each service)	**# Users**	**Avg. Units/User**	**Avg. Cost/Unit**	**Total Cost**
Enhanced Personal Care Services	**180**	**1,088**	**$11.88/hr.**	**$2,326,579**
Consultative Services	**45**	**72**	**$76.90/hr.**	**$249,156**
Respite Services	**90**	**728**	**$8.69/hr.**	**$569, 369**
Family Support/ Service Coordination (Supports Brokerage)	**180**	**6 ***	**$329. 58/month**	**$355, 946**
Environmental and Vehicle Modifications	**18**	**1**	**$3,965.00/mod.**	**$71, 370**
GRAND TOTAL:				**$3,572,420**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				**180**
FACTOR D (Divide total by number of recipients)				**$19,847**

*** Due to the consumer directed nature of this waiver, it is assumed that families will require less family support/service coordination (supports brokerage), but rather will utilize funds primarily for direct care and supports. However, if families wish to select 12 months of this service, they may build it into their service agreement.**

Year 2				
Waiver Service (Add row for each service)	**# Users**	**Avg. Units/User**	**Avg. Cost/Unit**	**Total Cost**
Enhanced Personal Care Services	**190**	**1,088**	**$11. 88/hr.**	**$2, 455,834**
Consultative Services	**48**	**72**	**$76. 90/hr.**	**$265,766**
Respite Services	**95**	**728**	**$8. 69/hr.**	**$601, 000**
Family Support/ Service Coordination (Supports Brokerage)	**190**	**6 ***	**$329. 58/month**	**$375, 721**
Environmental and Vehicle Modifications	**19**	**1**	**$3, 965.00/mod.**	**$75, 335**
GRAND TOTAL:				**$3, 773, 657**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				**190**
FACTOR D (Divide total by number of recipients)				**$19,861**

*** Due to the consumer directed nature of this waiver, it is assumed that families will require less family support/service coordination (supports brokerage), but rather will utilize funds primarily for direct care and supports. However, if families wish to select 12 months of this service, they may build it into their service agreement.**

Year 3				
Waiver Service (Add row for each service)	**# Users**	**Avg. Units/User**	**Avg. Cost/Unit**	**Total Cost**
Enhanced Personal Care Services	**200**	**1,088**	**$11. 88/hr.**	**$2, 585,088**
Consultative Services	**50**	**72**	**$76. 90/hr.**	**$276,840**
Respite Services	**100**	**728**	**$8. 69/hr.**	**$632,632**
Family Support/ Service Coordination (Supports Brokerage)	**200**	**6 ***	**$329. 58/month**	**$395,496**
Environmental and Vehicle Modifications	**50**	**1**	**$3, 965. 00/mod.**	**198,250**
GRAND TOTAL:				**$4,088,306**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				**200**
FACTOR D (Divide total by number of recipients)				**$20,442**

*** Due to the consumer directed nature of this waiver, it is assumed that families will require less family support/service coordination (supports brokerage), but rather will utilize funds primarily for direct care and supports. However, if families wish to select 12 months of this service, they may build it into their service agreement.**

PROJECTED AVERAGE LENGTH OF STAY IN WAIVER PROGRAM:

Year I-180 days

Year 2-230 days
Year 3-272 days

Please provide a narrative description and supporting documentation for the derivation of the following factors:

FACTOR D DERIVATION: **MMIS Paid Claims Data**

FACTOR D' DERIVATION: **MMIS Paid Claims Data**
FACTOR G DERIVATION: **HCFA 372 report for 9/1/99-8/31/00 for ICF/MR**
FACTOR G' DERIVATION: **HCFA 372 report for 9/1/99-8/31/00 for ICF/MR**

Appendix G-3 METHOD OF PAYMENTS (check one):

X Payments for all waiver and State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

Appendix G-4 – INDIVIDUAL BUDGET PROJECTIONS OF RESOURCES WITHIN THE EXCLUSIVE CONTROL OF THE FAMILY OR THE INDIVIDUAL. (This information is required, but will not be used in the calculations of cost neutrality.)

Please estimate the proportion of families or persons who will have annual individual budget amounts in the following ranges**: (See H below.)**

Budget Range	Proportion of Participants
$1 – 5,000	
$5001 – 10,000	
$10,000 – 15,000	
$15,001 – 20,000	**5%**
$20,001 – 25,000	**90%**
$25,001 – 50,000	**5%**
$50,000 – 75000	

$75,001 – 100,000	
$100,000 and above	
	100%

APPENDIX H – INDIVIDUAL BUDGETS

The following describes in detail EITHER:

The State's uniform methodology for the calculation of individual budgets, OR

The criteria and approval process for entities with which the State has contracted for day-to-day operations of the program.

This description addresses the minimum requirements that the methodology utilize actual service utilization and cost data, how the methodology is explained to the family or individual, the re-determination process, and how the methodology is open to public inspection.

Once a service agreement for a consumer is established, specific components within the Consolidated Developmental Service will be costed out by the Area Agency to construct an individualized budget. As is the case with planning of services, the family/individual will be provided the opportunity to fully participate and have the "lead voice" in the decision making process regarding the budget. Each budget will contain projected expenses for each service element identified in the individualized service agreement. These estimates will typically be based on the customary regional costs for the services being planned. The budget proposal will also include general management expenses which are capped at 12% within New Hampshire's system and will be listed as such in the individual budget. [In cases in which fiscal intermediary services are being provided, the costs for such services will be included as part of the overall general management expense.] Upon request, the methodology for determining individual budgets will be made available. The proposed budgets will be submitted to the Division of Developmental Services for the necessary State approval.

Once the child/individual is found eligible for the waiver and his or her budget is approved by the Division, required information regarding prior-authorization of services will be submitted to the New Hampshire's Medicaid fiscal intermediary, Electronic Data Systems. This information will identify the total waiver payments for the child's/individual's services under the Consolidated Developmental Service category. Based on the prior-authorization issued and actual provision of services, the Area Agency will submit claims and be reimbursed on a monthly basis.

To insure family/individual involvement and informed choice regarding use of the authorized funds, the Area Agency will provide the family/individual with monthly documents containing the following:

- **Line item breakdown of the expenditures to date;**
- **Information identifying the amount of funds still available from the authorized budget; and,**
- **Quality satisfaction feedback form to be returned to them regarding family's satisfaction level and any issues or concerns with the services being provided.**

Based on the monthly documentation of actual and projected expenses, the family support/service coordinator will assist the family in managing the available funds. Through the child/individual planning process, the family/individual will have the opportunity to request enhancements, i.e., increases to their budget. [Please see Appendix E regarding the flexibility afforded to families and individuals regarding use of the authorized resources.] The ultimate authority for approving such revisions will lie with the Division of Developmental Services.

For the proposed waiver, the State intends to set an annual maximum limit of $30,000 on all child/individual budgets. [This cap is based on the consideration that authorization of child/individual budgets higher than $30,000 would necessitate funding of other families with very low ($5,000 or less) amounts in order to achieve and maintain the statewide waiver average proposed for this waiver. Moreover, in establishing this limit, the State took into consideration the fact that authorizations beyond $30K would approximate New Hampshire's prevailing nursing home costs.]

In cases where the proposed modifications to the budget exceed the proposed waiver cap of $30,000, the Area Agency will continue to serve the child/individual and family with the authorized funds up to $30,000 and assist the family/individual to access the Medicaid State Plan services and other generic resources to address the additional needs.

As part of their overall financial responsibilities and the Division of Developmental Services' contractual expectations, the Area Agencies are required to undergo an independent year-end financial audit based on generally accepted accounting principles (GAAP). The services funded under the proposed waiver will be a part of this financial review.

APPENDIX I – PARTICIPANT PROTECTIONS

The State procedures and processes to assure that each of the following protections is in place are described below.

The State has procedures to assure that families and individuals have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation. Such functions are mandatory under the template and should be provided by one or more entities. The services and the provider qualifications are described in Appendix B.

As previously indicated in Appendix E and Appendix F, child/individual and family involvement in every facet of activities is a hallmark of New Hampshire's Developmental Services system. The Area Agencies are expected and oriented to provide information and assistance to children/individuals and families regarding all aspects of their services. Accordingly, once a family expresses interest regarding in-home supports, but before services are delivered, the Area Agency staff will discuss with the family/individual their specific needs and provide the following:

- **Explanation of services available to the individual/family both through the In-Home Supports Waiver and the Medicaid state plan services, as well as the benefits and limitations of different Medicaid programs relative to the individual's/family's needs;**
- **Explanation of agency managed and consumer directed models of service delivery;**
- **Description of the service planning process and development and implementation of the service agreement;**
- **Identification of possible providers, including people known to the family such as extended family, neighbors, or others in the local community;**
- **Description of the oversight of services provided under the waiver;**
- **Identification of the responsibilities of providers (including family support/service coordinators) and family members in the provision of services and supports;**
- **If the child/family is taking medication, information regarding the supports available or needed to administer the medication safely;**
- **If applicable, an explanation of alternative approaches to behavioral intervention, including a description of theory, practice, strengths and expected outcomes of the methods; and**
- **Description of Cost of Care requirements, if applicable.**

The staff involved in the service arrangement will invite and support the family/individual to exercise choice and control over their service options and arrangements. The family support/service coordinators will provide the necessary information to the family/individual to help them make informed choices during

service planning and provision. Moreover, the family support/service coordinator will insure that the individualized service agreement reflects the specific needs and preferences of the family/individual, identifies the persons responsible for provision of different supports, documentation requirements, specific contingency plans for assuring provision of service when usual providers are not available, and emergency contact information, including documentation that all providers, and family members are aware of the information and are able to carry out making the contact in a variety of situations.

In addition, to protect the interest of the individual/family the Area Agency staff will establish a formal contract when in-home supports are to be provided by a subcontract agency, specifying the role of the subcontract agency in service planning, provision and oversight. The contract will also include the following:

- **Implementation of the child/family service agreement;**
- **Specific training and supervision required for the service providers;**
- **Quality assessment and improvement activities as required by rules and service agreement;**
- **Compensation amounts and procedures for paying in-home support providers;**
- **Documentation of administrative activities and service provision;**
- **Compliance with applicable laws and regulations, including delegation of tasks by a nurse to unlicensed providers per RSA 326;**
- **Procedures for review and revision of the contract as deemed necessary by any of the parties; and**
- **Provision for any of the parties to dissolve the contract with notice.**

When a family chooses in-home support services to be provided by an entity other than the Area Agency or subcontract agency, the Area Agency will discuss the items specified above under subcontractor managed services with the family/individual to enable them to make informed choices regarding the roles and responsibilities of the family, providers and; and establish a contract with the family, which specifies the parties responsible for the items listed above.

Based on discussions with and preferences of the family/individual, the Area Agency or subcontract agency will provide training, and support to the in-home support providers in the following areas:

- ❑ **Understanding and knowledge of the disability of the child/individual and of how the disability may effect the child's/individual's participation in everyday activities;**
- ❑ **Using techniques specific to communicating with the child/individual and to carrying out specific activities of daily living, including the use of adaptive equipment;**
- ❑ **Supporting the child/individual to maintain and improve his/her quality of life in the family home and local community by promoting:**
  - **The child's/individual's development of age-appropriate values, family and social roles;**

- **The child's/individual's building of relationships with family, friends, and neighbors; and**
- **Opportunities for the child/individual to participate in local community events and organizations;**

- ❑ **Understanding challenging behaviors and facilitating more positive behaviors;**
- ❑ **Using instructional techniques to assist learning;**
- ❑ **Assuring basic health and safety practices;**
- ❑ **Understanding and carrying out provision of services in ways which support personal rights;**
- ❑ **Understanding procedures necessary to insure safe administration of medications if the child/individual is taking medication.**

Under New Hampshire's In-Home Supports Waiver intermediary services, as part of the overall general management cost, will be available to the family/individual through the Area Agency or a subcontract agency. To facilitate the delivery of consumer-directed services, intermediary services will provide an array of fiscal and administrative supports such as:

- ❑ **Collecting and verifying worker timesheets;**
- ❑ **Preparing and disbursing payroll checks;**
- ❑ **Computing tax withholdings;**
- ❑ **Filing and depositing employment taxes;**
- ❑ **Processing and paying non-labor related invoices;**
- ❑ **Processing criminal background checks on prospective workers; and**
- ❑ **Generating standardized reports depending on service design or fiscal arrangements.**

Upon family or individual request, the State makes available at no cost, provider qualification checks, including criminal background checks.

The Area Agency or subcontract agency will perform criminal background checks on all people, including family members and friends, who are being considered for a position of staff or provider at no cost to the family/individual.

The State has procedures to promote family or individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

As stated before, consumer choice and control will be a prominent aspect of New Hampshire's In-Home Supports Waiver. Services provided under the waiver will be specifically tailored to the competencies, interests, preferences, and needs of the child/individual and his or her family and respectful of the cultural and ethnic beliefs, traditions, personal values and lifestyle of the family/individual. In extending the family/individual choice and control over their service arrangements,

the family support/service coordinator will provide information and assistance to facilitate and optimize consumer participation and direction. Responsiveness to family/individual preferences and requests will occur within the context of state and federal laws and regulations and policies of the Area Agency. Beginning with the initial discussion about in-home supports, the Area Agency staff will make a point of sharing information with the family/individual regarding such expectations, requirements and limitations. Moreover, service agreements and contracts with the family/individual will document not only consumer choice and control but also responsibilities of the different parties involved in the service arrangement and compliance with laws and regulations.

The State has a viable system in place for assuring emergency back up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

All of the Area Agencies operating within New Hampshire's Developmental Services System have established 24-hour, 7-days-a-week emergency response capability. Regardless of the type of service arrangement employed (agency managed or consumer directed model of service), the family/individual and providers will be able to utilize this on-call system for emergency situations.

Moreover, through the child/individual planning sessions, the people involved in supporting the child/individual will also identify, discuss and plan for emergencies based on the unique needs and circumstances of the child/individual and his or her family.

The State has procedures for how it will work with families and their employer agents (if applicable) to monitor the ongoing expenditures of the individual budgets.

As part of their responsibility for facilitating and monitoring service arrangements, the family support/service coordinator or other staff designated by the Area Agency will review the actual expenditures and revenues of the individualized budget and assist the family/individual and providers in managing the authorized funds. This review will be based on the monthly financial reports generated by the business office of the (or subcontract agency or fiscal intermediary, as applicable) which will identify the expenditures and revenues to-date, as well as projecting year-end budget status based on the financial activities and trends to-date.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

If the over-expenditure is due to unforeseen or emergency consumer needs, a request may be made to the Division of Developmental Services to augment the child/individual budget. In such cases, the Area Agency will be expected to submit documentation to the Division of Developmental Services providing information regarding the nature of the problem and the specific breakdown of the additional costs.

The state may increase the child's/individual's budget (up to the waiver cap amount of $30,000) either for a short-term or permanent basis, based on the nature of the needs identified and availability of funds under the waiver. In cases where such an increase cannot be achieved or the child's/individual's current budget is already at the $30, 000 level, the Area Agency will continue to provide services under the waiver and assist the family/individual to access the Medicaid State Plan services and other generic resources to support their needs.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination**.**

Decisions regarding unexpended resources at the time of redetermination will be made through a joint discussion held by the family/individual and Area Agency staff. (This may be done as a part of the service planning process.) If such discussions lead to the conclusion that the unspent resources can be returned to the system permanently without any negative impact for the individual/family, the Division will reduce the individual's total authorization under the waiver beginning with the new prior authorization cycle and use the returned funds to provide services for other individuals/families.

The State has a viable system by which it receives, reviews and acts upon critical events or incidents (states must describe critical events or incidents). This system may include an existing process (e.g. child or adult protective services). This system must be part of the Quality Assurance and Improvement Program.

The Division of Developmental Services' Office of Client and Legal Services (OCLS) receives and reviews information regarding investigations completed by the Area Agencies (See Appendix F). This information is used to identify system-wide trends and needs (e.g., training, recruiting, report writing).

In addition, the Division of Developmental Services receives medication error reports and mortality information from the Area Agencies and utilizes this to inform systemic compliance and quality improvement initiatives.

Supplements Attached:

He-M 202, 309, 310, 503, 505, 506, 510, 513, 517, 1201;
Proposed Rule He-M 524;
In Home Support Waiver Tables;
Family Assistance and Adult Assistance Manuals-
See-
http://www.dhhs.state.nh.us/DHHS/MEDASSISTELIG/LIBRARY/Manual/A1.htm
Medicaid State Plan-See-http://www.hcfa.gov/medicaid/stateplan/toc.asp?state=NH
Patient Care Referral forms 276 A and B and Utilization Review form 277-
Submitted previously.